Enrollment Form

Anthem

Section 1: Personal information

Last name (print)	First name (print)	M.I.	Effective date (MMDDYY)	Group no.

Date of birth (MMDDYY)	Social Security no.	Sex	Marital status	Phone no.
		☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced	

Mailing address ☐ Check here if this is an address change	City	State	ZIP code (5+4)

Employer	Date hired/rehired (MMDDYY)	Employee no.	Email address

Section 2: Plan options (indicate with a check mark)

Type of coverage: ☐ New Enrollment ☐ Open Enrollment ☐ Plan change

Medical plan: ☐ Active PPO ☐ Bronze PPO ☐ Blue Card PPO (AZ, CO, NM, TX, UT)

Backup documents (copies) are **required** for all dependents you enroll (marriage certificate, birth certificate with parent's full names).

Section 3: Employee and family information — Please list yourself and all eligible family members to be enrolled. Attach additional sheets if necessary.

	Sex	Last Name	First Name	MI	Date of birth (MMDDYY)	Social Security no. (required)	Age	Dependent to be added or removed
Self	☐ M ☐ F							☐ Added ☐ Removed
Spouse	☐ M ☐ F							☐ Added ☐ Removed
Child	☐ M ☐ F							☐ Added ☐ Removed
Child	☐ M ☐ F							☐ Added ☐ Removed
Child	☐ M ☐ F							☐ Added ☐ Removed
Child	☐ M ☐ F							☐ Added ☐ Removed
Child	☐ M ☐ F							☐ Added ☐ Removed

Section 4: Medicare

Are you retired? ☐ No ☐ Yes If "Yes," for Medicare for you: **Part A**? ☐ Yes ☐ No **Part B**? ☐ Yes ☐ No

Do you or your dependents have Medicare? ☐ No ☐ Yes If "Yes, " for your dependent: **Part A**? ☐ Yes ☐ No **Part B**? ☐ Yes ☐ No

Name(s) of Medicare dependent(s): _____

Name(s) of Medicare dependent(s): _____

Name(s) of Medicare dependent(s): _____

If "Yes," for Medicare for you and/or your dependent(s) please provide your and/or their HIB number and indicate the entitlement reason and Medicare eligibility date for yourself and/or your dependent(s).

HIB #: _____ Entitlement reason: ☐ Over 65 ☐ Disabled ☐ ESRD Effective date of Medicare: _____

Name: _____

HIB #: _____ Entitlement reason: ☐ Over 65 ☐ Disabled ☐ ESRD Effective date of Medicare: _____

Name: _____

Sections 5–8: Please read carefully

5. **Non-participating provider**: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
6. **HIV testing prohibited**: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
7. **Effective date**: The effective date of coverage is subject to Anthem Blue Cross approval.
8. **Arbitration agreement**:

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES, INCLUDING, BUT NOT LIMITED TO, DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING, BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. *It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and as provided by federal and California law, including, but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.* THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND PARTICIPATION IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

Section 9: Signature of understanding

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Employee signature	Date (MMDDYY)
X	

Please retain a photocopy for your records and submit this form to CSAC, 533 S. Fremont Avenue, 6th floor, Los Angeles, CA 90071.